Governor's Council on Substance Abuse Report
Access to Substance Abuse Treatment In Washington State

Dr. Priscilla Lisicich, Council Chair
Dr. Carol A. Owens, Staff Coordinator

January 2000

WASHINGTON STATE COMMUNITY, TRADE AND ECONOMIC DEVELOPMENT
Building Foundations for the Future

Martha Choe, Director

Busse Nutley, Assistant Director for Community Development

GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE

MISSION:

It is the mission of the Governor's Council on Substance Abuse to reduce substance abuse in Washington State.

This includes reducing the abuse of alcohol, tobacco, drugs and other materials that individuals may abuse, including over-the-counter medications, gasoline and glue.

VALUES:

We will work collaboratively while also recognizing diversity, combining efforts in the private, public, tribal, and nonprofit sectors.

Whenever possible, we will build on and strengthen effective structures, systems, and organizations that are addressing substance abuse, rather than develop new programs.

We will develop balanced and accountable strategies for reducing substance abuse, not emphasizing one approach over another, but recognizing that a complex set of problems requires more than one method of resolution.

RESPONSIBILITIES

The Governor's Council on Substance Abuse will:

Develop recommendations, based on community and agency input and involvement, for state and local strategies on substance abuse;

Advise the Governor on substance abuse issues;

Review and develop recommendations regarding state, local and federal funding of substance abuse programs;

Advise the Family Policy Council on substance abuse issues through a collaborative process; and

Provide policy recommendations to state agencies on alcohol, tobacco and other drug issues.

GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE REPORT
ACCESS TO SUBSTANCE ABUSE TREATMENT IN WASHINGTON STATE

A Report to the Legislature from
Department of Community, Trade and Economic Development
Local Government Division
Steve Wells, Assistant Director

Prepared by

Dr. Priscilla Lisicich, Council Chair
Dr. Carol Owens, Staff Coordinator

January 2000

ACKNOWLEDGEMENTS

The production of this report could not have been accomplished without the generous assistance of many individuals and organizations. Among those, the Council would like to acknowledge the following for their contributions of time, effort, and expertise:

The Council and other Washington State Community, Trade and Economic Development staff who put in long hours over many months to develop and complete the research and writing of this report.

Carol Owens for project management and design.

Joli Sandoz for research and report writing.

Rick Vargas and Eric H. Larson for countless meeting arrangements, proofreading and formatting efforts.

Division of Alcohol and Substance Abuse
Doug Allen and Fred Garcia

Office of the Superintendent of Public Instruction
Denise Fitch

The Boeing Company
Dennis O'Neill

Community Representative from Olympia, Washington
Rick Teboe

Clark County Department of Community Services
Cleve Thompson

For more information, or to request copies of this or other reports from the Governor's Council on Substance Abuse, contact Council staff at (360) 753-5626.

GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE

WASHINGTON STATE COMMUNITY, TRADE AND ECONOMIC DEVELOPMENT — BUILDING FOUNDATIONS FOR THE FUTURE

August 4, 2000

The Honorable Gary Locke
Governor, State of Washington
Legislative Building
Post Office Box 40002
Olympia, Washington 98504-0002

Dear Governor Locke:

I am pleased to forward to you the results of a 1999 policy study on issues related to Access to Treatment that currently impact the residents of the state of Washington.

The Council undertook this study to provide a more in-depth analysis for your use, and for use by others interested in the impacts of drug abuse policy in Washington State. We see this as a crucial issue facing all communities in Washington State.

In summary the Council would like to recommend the following for your consideration:

- Expanding the capacity of involuntary treatment services for chemically dependent and mentally ill adults to provide services in Eastern Washington;
- Enhancing grants to Indian tribes for treatment and prevention programs;
- Increasing secure treatment capacity for chemically dependent, female youth;
- Improving access and capacity for youth detoxification and crisis stabilization services; and
- Expanding the availability and capacity of drug courts.

We sincerely hope the information provided by this policy study will be of use to you and your office in dealing with current policy regarding Access to Treatment in Washington State. Please contact me or Council staff if you need additional information or assistance during your consideration of these recommendations.

Sincerely,

Priscilla Lisicich, PhD
Council Chair

cc: Dick Van Wagenen, Governor's Executive Policy Office
Dick Thompson, Director, Office of Financial Management
Busse Nutley, Deputy Director for Community Development, CTED

GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE

LONG-TERM GOALS FOR REDUCING SUBSTANCE ABUSE

PREVENTION

1. Prevent and reduce the misuse and abuse of alcohol, tobacco, and other drugs.

2. Focus on outcome-based prevention strategies to increase the effectiveness of prevention efforts.

3. Increase the community ownership and responsibility for prevention of misuse of alcohol, tobacco, and other drugs.

TREATMENT

1. Increase access to and availability of chemical dependency treatment, as clinically necessary.

2. Reduce the negative effects of alcohol, tobacco and other drugs.

3. Address the basic needs of people in chemical dependency treatment.

LAW AND JUSTICE

1. Increase public safety.

2. Increase the effectiveness of law and justice efforts to reduce alcohol and other drug abuse-related crimes.

3. Foster citizen involvement and support for effective law and justice efforts, including community-oriented policing.

GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE REPORT
ACCESS TO SUBSTANCE ABUSE TREATMENT
IN WASHINGTON STATE

Introduction

How accessible is treatment for substance abuse in Washington State? How many residents need treatment? What do treatment opportunities look like? Do those who need treatment get it? How much does the social fabric of our state unravel each time a person who needs treatment is unable to obtain it? What policy actions can increase Washington residents' access to treatment?

Behind these questions lies a turmoil of complex issues, many of which have not been dealt with directly at any time in the state's history. Interest in resolving them now is exceptionally high, as indicated by a geographically representative telephone survey of 1,568 state residents in 1997. Respondents rated "access to health care" and "alcohol/drugs" as the two most important health areas on which state government should work. Together the two issues–both closely related to the subject of this white paper–received 43.1 percent of respondents' votes. Nine of ten survey respondents (90 percent) also ranked misuse of alcohol and other drugs as the most serious of a list of ten health concerns then before the State Board of Health. In answering the same question, 71 percent of respondents rated access to health services as "serious" or "moderate" in their estimation.)[1]

Legislative Findings and Intent Regarding Chemical Use and Dependency

Washington State's legislature has characterized the use of alcohol and other drugs as a "serious threat" to citizen health and a "primary crippler" of youth. Additional legislative findings note the costs to individuals, families and society, and the importance of treatment in recouping those costs. RCW 70.96A.011 states that "it is the intent of the Legislature…. to ensure that prevention and treatment services are available and are of high quality…. Public money spent on treatment saves not only the life of the chemical abuser, it makes us safer as individuals, and in the long-run costs less." Emphasis on provision of prevention and treatment services follows on the Legislature's recognition of chemical dependency as a disease. [2]

Definitions and Concepts

Levels and patterns of drug consumption, and the severity of resultant functional impairment, usually identify alcohol and other drug abuse.[3]

In this white paper, a distinction is made between "abuse" (as in "substance abuse"), and "addiction" or "dependency" (as in "chemical dependency"), to emphasize the progressive nature of these levels and patterns, and the need for a continuum of treatment services targeted to each stage.

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[1] *1998 Washington State Public Health Report*. Olympia, WA: Washington State Board of Health. 1998. 6-7.
[2] Revised Codes of Washington. Chapter 70.96A RCW (Codified 9/98). "Treatment for Alcoholism, Intoxication, and Drug Addiction." 3, 5.
[3] Lillie-Blanton, Marsha. "Drug Abuse: Studies Show Treatment Is Effective, but Benefits May Be Overstated." Testimony before the Subcommittee on National Security, International Affairs and Criminal Justice, Committee on Government Reform and Oversight, U.S. House of Representatives. U.S. General Accounting Office. GAO/T-HEHS-98-185. July 22, 1998. 2.

Washington State law, especially RCW 70.96A.020 and Washington's Administrative Code (WAC), define the following terms relevant to this report:

> Alcoholism: A primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.[4]
>
> Chemical Dependency: A person's alcoholism or drug addition or both.[5]
>
> Drug Addiction: A primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over use of drugs, preoccupation with drugs, use of a drug despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.[6]
>
> Substance Abuse: A recurring pattern of alcohol or other drug use which substantially impairs a person's functioning in one or more important life areas, such as familial, vocational, psychological, physical, or social.[7]
>
> Treatment Services: Broad range of emergency, detoxification, residential, and outpatient services and care, including diagnostic evaluation, chemical dependency education, individual and group counseling, medical, psychiatric, psychological, and social services, vocational rehabilitation and career counseling.[8]

Where researchers and others whose work appears in the rest of this paper have not distinguished between "abuse" and "addiction/dependency" that will be noted, if known.

Addiction, while perhaps the most commonly thought-of stage of substance use in relation to treatment, is in fact only the tip of a pyramid of use patterns for which intervention is vital. Non-users make up the base, then levels in ascending order might be labeled "experimenter," "habitual user," "abuser," and finally "addict."

If substance use can be thought of as a continuum, so can intervention. The following diagram depicts the interrelationship between specific use levels and the related appropriate interventions. Much can be done, including education and counseling, to help prevent individuals from developing more serious problems. Treatment as such is the most effective intervention once use escalates to abuse/addiction.[9]

Recent research shows that the most effective treatment addresses physical, psychological and social factors; it takes in a wider scope than an individual's use of substances to consider family and community dynamics, and the practical issues of employment, housing, child care, and the

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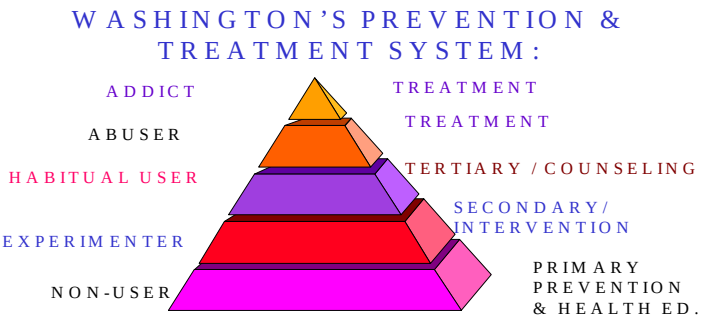
[4] Washington Administrative Code, Chapter 440-22-005 Definitions. 3.
[5] Washington Administrative Code, Chapter 440-22-005 Definitions. 3.
[6] Washington Administrative Code, Chapter 440-22-005 Definitions. 5.
[7] Washington Administrative Code. Chapter 440-22-005 Definitions. 6.
[8] *WAC Implementation Guide*, October 9, 1997. Olympia, WA: Certification Section, Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services. 8.
[9] Fred Garcia, Office Chief of Prevention and Treatment Operations. Olympia, WA: Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services. August, 1999.

like. Markers of treatment success include reduced substance use, better physical health, and improved functioning at school and/or on the job as well as in family and society.[10]



Background: Prevalence of Substance Abuse and Chemical Dependency in Washington State

Alcohol and illicit drug use occur in every segment of Washington State's population. Actual prevalence varies from subgroup to subgroup as defined by such characteristics as age, gender, and employment and racial/ethnic status. But problems related to chemical use and dependency are widespread; in FY 1994, some 15 percent of Washington's adults living in households reported a lifetime diagnosis of substance abuse or dependence, as defined by American Psychiatric Association guidelines, and 10.5 percent (399,383 adult state residents) currently needed treatment.[11 a]

At present, a periodic survey sponsored by the Office of the Superintendent of Public Instruction and administered through a percentage of the state's schools to sixth, eighth, tenth and twelfth graders is the state's only data source for prevalence of drug and alcohol use and abuse among the general adolescent population. (The state's Division of Alcohol and Substance Abuse [DASA], in the Department of Social and Health Services [DSHS], is currently conducting a household survey which will yield additional prevalence data). Some 52,316 students returned valid surveys in 1998.[12] Among high school seniors only, 52 percent reported using alcohol in the past 30 days, 28.7 percent had used marijuana, and 2.6 percent said they had used cocaine.[13]

[10] Landry, Mim J. *Overview of Addiction Treatment Effectiveness*. Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. February, 1997. 10-13.
[11] Kabel, Joseph, et. al. *Substance Use, Substance Use Disorders, and Need for Treatment in Washington State Adults: Findings from the 1993-1994 Washington State Needs Assessment Household Survey*. Olympia, WA: Office of Research and Data Analysis, Washington State Department of Social and Health Services. Report No. 4.25-40. December 1996. 26-27, 30.

[12] Deck, Dennis et al. *Washington State Survey of Adolescent Health Behaviors, 1998. Technical Report*. Olympia, WA: Office of Superintendent of Public Instruction. November, 1998. 30-31.
[13] Deck, Dennis et al. *Washington State Survey of Adolescent Health Behaviors, 1998. Technical Report*. Olympia, WA: Office of Superintendent of Public Instruction. November, 1998. 40.

The overall results revealed that Washington State students at various grade levels appear to be more likely than their peers nationally to have:

- Smoked marijuana in the past 30 days (10th graders and seniors);
- Drunk alcohol in the past 30 days (10th graders);
- Used cocaine in the past 30 days (10th graders); and
- Engaged in recent heavy drinking (10th graders and seniors).[14]

Based on results from the 1995 survey, DASA researchers concluded that almost 12 percent of Washington State students have a substance abuse problem by their senior year.[15]

Background: Economic Cost of Substance Abuse and Chemical Dependency in Washington State

The most recent year for which cost data is available to quantify Washington's economic burden resulting from substance abuse and chemical dependency is 1996. Using conservative estimating techniques, researchers found the total economic price tag of drug and alcohol abuse and addiction to be $2.54 billion, or roughly $531 per non-institutionalized state resident. In order of cost, the areas analyzed were:

- Premature death ($929 million);
- Crime ($541 million);
- Reduced productivity ($369 million);
- Other related costs (associated mostly with property damage from motor vehicle accidents; $254 million);
- Medical care ($211 million);
- Treatment ($160 million); and
- Other diseases (costs of Acquired Immune Deficiency Syndrome and Hepatitis B associated with injection drug use, and fetal alcohol syndrome; $81 million).[16]

The authors of the report note that the approach they used quantifies a person's value to society in terms of production as reflected in earnings,[17] the depth of human suffering, and the damaging or destruction of human value in non-economic terms, caused by substance abuse and addiction are over and above the $2.54 billion figure.

Background: Cost Benefits of Providing Substance Abuse and Chemical Dependency Treatment

National studies show that treatment leads to reduced substance use, and to increased employment as well as reduced criminal justice system involvement, family and school

[14] Beretta, Gina R. *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State: 1999 Report.* Olympia, WA: Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services. DSHS 22-055 (Rev 1/99). January 1999. 9-15.
[15] Krupski, Antoinette. "Substance Use and Abuse Among Washington State Adolescents." Olympia, WA: Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services. August 21, 1996. 6.
[16] Wickizer, Thomas M. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996.* Olympia, WA: Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services. March, 1999. vii-viii,49.
[17] Wickizer, Thomas M. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996.* Olympia, WA: Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services. March, 1999. 2-3.

problems, medical costs and use of sick time.[18] Because of varying methodologies employed in, and inconsistencies between, studies in terms of types of clients, treatments studied and substances abused, it is difficult to assess the exact amount of economic cost offset to be gained from substance abuse and dependency treatment in general.

A draft literature review of selected research studies on medical and criminal justice cost-offsets provided by chemical dependency treatment, completed by DSHS Research and Data Analysis staff, discusses strengths and weaknesses of research conducted across the country. The review's authors concluded that most studies find evidence of reduced medical and criminal justice costs and increased likelihood of employment, subsequent to treatment.[19]

Researchers in Washington State have tracked cost data for several outcomes of publicly funded treatment. In a program for indigent, unemployable clients incapacitated due to drug and alcohol addictions, treated clients over a five year follow-up period used an average of $4,500 less in Medicaid medical services than untreated clients.[20] Substance abusing women who received chemical dependency treatment prenatally were less likely to have a low birth weight baby (a condition which results in higher medical costs during the first two years of life). Average Medicaid costs for medical care during the first two years of life were also lower for babies of treated mothers.[21]

Several other measurable outcomes of public treatment services in Washington State undoubtedly offset treatment costs, at least to some extent. In the 18 months after treatment, for example, adolescents reduced their substance use, accessed medical services less frequently, functioned significantly more effectively at school and work, and reduced their involvement with legal supervision.[22] Criminal arrests and the use of health services decreased among clients during opiate substitution treatment as compared to the year prior to treatment.[23]

In outlining the implications of his recent review of economic costs of alcohol and drug abuse and addiction in Washington state (discussed in the previous section), University of Washington professor Thomas Wickizer noted that for every $1 the state collected in alcohol tax revenue during fiscal year 1996, $12 was spent as a result of alcohol abuse and dependency. He went on to observe that "the gap between treatment need and access . . . suggests a continued necessity to consider whether current resources for treatment and prevention are adequate" in this state. Certainly the $160 million expended for treatment in Washington in 1996 compares unfavorably to the $2.54 billion price tag for substance abuse as a whole.

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[18] Landry, Mim J. *Overview of Addiction Treatment Effectiveness.* Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Feb, 1997. 12.

[19] Kohlenberg, Liz, et al. "Improve DSHS Client Outcomes and Reduce DSHS Costs by Increasing Treatment for Alcohol/Drug Problems Among DSHS Clients." Draft (Version 4). Olympia, WA: Research and Data Analysis, Washington State Department of Social and Health Services. 13-18. October, 1998.

[20] Luchansky, Bill and Dario Longhi. "Briefing Paper: Cost Savings in Medicaid Medical Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State." Briefing Paper #4.30. Olympia, WA: Research and Data Analysis, Washington State Department of Social and Health Services. June, 1997.

[21] Beretta, Gina R. *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State*. Olympia, WA: Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services. DSHS 22-055 (Rev. 1/99). January, 1999. 157-160.

[22] New Standards. "Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report." St. Paul, MN: New Standards, Inc. August, 1997. i - iv.

[23] Beretta, Gina R. *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State*. Olympia, WA: Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services. DSHS 22-055 (Rev. 1/99). January, 1999. 177-178.

Substance Abuse and Chemical Dependency Treatment in Washington State: An Overview

On October 1, 1996, substance abuse treatment programs in this state reported some 5,514 persons in treatment.[b] Ninety-two percent of this number received outpatient services; 8 percent were inpatients. Treatment for more than one-third (37 percent) focused on alcohol problems only; 16 percent received treatment for drug problems only; and treatment for the remaining 47 percent addressed dual abuse problems. The population of people in treatment generally reflected the state population by age and ethnic group, except that whites and Asians were somewhat underrepresented, and African Americans and Native Americans were over-represented.[24]

Providers reported during the census–a national effort administered by the U.S. Department of Health and Human Services, and termed the 1996 United Facility Data Set (UFDS)–that funding for direct treatment to individuals in Washington state came from a variety of payers. The federal government was the largest single source (some 22.9 percent of all treatment funding, not including Medicare [an additional 2.1 percent] or Medicaid [an additional 9.1 percent] funds). Client payments (21.7 percent), state funding (19.2 percent), and private health insurance (18.5 percent) came close behind. Some 85 percent of specialty substance abuse treatment facilities actually reported data, resulting in a conservative figure of $160 million as the total estimated private and public cost of providing treatment in Washington State during 1996.[25] Facilities in the District of Columbia, Washington state, and New York reported the highest census of clients in treatment relative to each 100,000 of state population (974, 775, and 774 respectively).[26]

Washington residents access treatment services through freestanding non-residential centers, hospitals and residential facilities, correctional institutions, military bases, halfway houses, community alcohol and drug treatment programs, some mental health centers, and some schools. The state's major public resource for chemical dependency treatment is DSHS, which funded treatment for 32,908 adolescents and adults in calendar year 1998 through DASA.[27] DASA does not administer treatment facilities; instead, qualifying indigent and low-income clients assessed as alcoholic or drug addicted receive a continuum of services provided through contracts with county governments, Indian tribes and non-profit service providers. Prevention and intervention specialists in the schools refer students to treatment. There are a few school districts that have treatment programs certified by the Department of Social and Health Services and provide treatment.

Washington State law (RCW 70.96A.045), and WAC 440-22-010 outline a voluntary certification process, which state law requires for providers contracting with DSHS for provision

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[24] Wickizer, Thomas M. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996.* Olympia, WA: Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services. March, 1999. 6-7. Data from the 1996 Uniform Facility Data Set Survey funded by the U.S. Department of Health and Human Services through the Substance Abuse and Mental Health Services Administration.

[25] Kabel, Joseph, et. al. *Substance Use, Substance Use Disorders, and Need for Treatment in Washington State Adults: Findings from the 1993-1994 Washington State Needs Assessment Household Survey*. Olympia, WA: Office of Research and Data Analysis, Washington State Department of Social and Health Services. Report No. 4.25-40. December 1996. 4-5. Data from the 1996 Uniform Facility Data Set Survey funded by the U.S. Department of Health and Human Services through the Substance Abuse and Mental Health Services Administration.

[26] Ezeh, Alex and Beth Sundberg. *Uniform Facility Data Set (UFDS): Data for 1996 and 1980-1996.* Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, December, 1997. Table 3. n.p.

[27] Data from the Treatment and Assessment Report Generation Tool (TARGET), January 1, 1998 to January 1, 1999. Communication from Fritz Wrede, Division of Alcohol and Substance Abuse, Washington Department of Social and Health Services. May 24, 1999.

of publicly funded chemical dependency treatment services. Other laws require that deferred prosecution assessments and treatment (RCW 10.05), and assessments, education or treatment services related to arrest or conviction for the operation of motor vehicles while under the influence of alcohol or other drugs (RCW 46.61) be completed by certified providers. Many third-party payers in Washington State also require state certification for provider reimbursement through clients' health insurance.

As of May 1999, DASA lists indicated that 82 agencies were certified to provide residential treatment services, and 433 to provide outpatient services; a total of 2,953 beds were licensed in the residential category.[28] Certification takes in on-going reviews and technical assistance visits focused on a program's services related to substance abuse and addiction. The agency publishes an annual "green book*" Directory of Certified Chemical Dependency Treatment Services in Washington State* which provides contact and services information.

Washington State requires that certified chemical dependency treatment services be staffed by professionals credentialed in the field. (See especially WAC 440-22-320 and 325). During the 1998 legislative session, lawmakers passed RCW 18.205, which established certified chemical dependency counselors as "discrete health professionals," and moved the credentialing process from DASA to the state's Department of Health. As of August 1999, the number of people holding a current chemical dependency Certificate of Qualification or a Letter of Enrollment (for interns) issued by DASA was 3,607.[29]

In the U.S. as a whole, the chemical dependency treatment system is often thought of as consisting of two categories distinguished by funding source: the public (publicly-owned programs, not-for-profit programs largely funded by government sources), and the private (privately-owned programs–some for-profit and some not-for-profit–serving clients who pay for treatment themselves or through private health insurance).[30] National studies have shown that the two categories of treatment program differ in a number of ways, from capacity utilization, service intensity (number of clients per counselor, for example) and treatment duration, to client characteristics including degree of life stability.[31] In Washington State, however, the distinction between "private pay" and "public pay" is blurred, as both publicly funded and private pay clients may receive certified services through the same treatment program.

Access to Substance Abuse and Chemical Dependency Treatment in Washington State

<u>The Complex Mix of Need, Capacity and Treatment Participation</u>

Results from in-person interviews of 598 adult arrestees booked into Washington State's King, Whatcom, and Yakima County jails during 1995 illustrate the complex interaction of need, accessibility, and the characteristic denial associated with substance abuse and dependency in determining actual participation in substance abuse treatment programs. Interviewees reported substance abuse/addiction at rates much higher than those of the general population; between 56 percent and 79 percent of arrestees interviewed (depending on the site) were assessed as needing treatment at the time of the interview (as compared to 8 percent to 11 percent of the general

[28] "May Monthly Status of All Agencies." Olympia, WA: Certification Section, Division of Alcohol and Substance Abuse, Washington Department of Health and Social Services. May 4, 1999. n.p.
[29] "DASA Counselor/Intern Credential Report." From DASA database. Olympia, WA: Certification Section, Division of Alcohol and Substance Abuse, Washington Department of Health and Social Services. August 18, 1999.
[30] "Two Tiers--Public and Private Supply." (Chpt. 6). *Drug Abuse Services Research Series No. 2*. National Institute on Drug Abuse, U.S. Department of Health and Human Services. 1992. 155-156.
[31] "Two Tiers--Public and Private Supply." (Chpt. 6). *Drug Abuse Services Research Series No. 2*. National Institute on Drug Abuse, U.S. Department of Health and Human Services. 1992. 161.

population in the counties studied).[c] Of this group, only about one-third (28 percent to 37 percent) admitted a need for treatment; in other words, some two-thirds (between 63 percent and 72 percent) denied this fact. Roughly one-third (35 percent) of arrestees at all three sites who were identified as needing substance abuse treatment had been able to obtain at least some during the prior year; an additional 20-25 percent of those needing treatment said that they had desired treatment in the year prior to the interview, and most of this group said they had made some active but unsuccessful attempt to seek it out. Between 74 percent and 90 percent of those who needed treatment and said they would have sought it during the past year had it been available to them also stated they would utilize substance abuse treatment services if offered to them while in jail, even if participation in treatment did not result in a deferral of jail time.[32]

Alcohol and drug abuse comprises behaviors at once illegal and socially stigmatized. In addition, denial is a well-documented aspect of the diseases themselves. These factors work against identification of need for, and self-referral to, treatment; obviously, numbers of people actually in treatment may not be revelatory of much about actual population prevalence of *need* for treatment. Should policy makers measure capacity against raw need–that is, against the number of people abusing alcohol and illegal drugs? Or should they use some measure of demand, the number of people who express a willingness to seek treatment, to judge whether treatment opportunities available are enough?[33]

According to research published by National Institute on Drug Abuse, a combination of first estimating need for treatment, and then identifying among that group people who are "good candidates" for treatment, generally marks efforts to determine necessary drug treatment capacity. However, the second step in this process, as the authors point out, is highly speculative due to the present lack of solid research about the effectiveness of various approaches to treatment.[34] National (though unofficial) federal health objectives gathered in the public comment draft of *Healthy People 2010* define "treatment gap" straightforwardly, as "the difference between the number of people who need treatment for the use of illicit drugs and the capacity of the treatment system to provide that treatment." The authors of *Healthy People 2010* comment that the exact size of the national gap between services "available" and "needed" simply hasn't yet been fully defined or quantified for treatment for either illicit drug use or problem drinking,[35] an observation which also holds true for Washington State.

Treatment Capacity in Washington State

At a very practical level, availability of "slots" for treatment determines when–and in some cases, whether–a person ready for substance abuse treatment can participate in it. Capacity in outpatient programs is difficult to measure, since it is flexibly adjusted by changing duration of treatment sessions and staff caseloads, and treatment practices are still evolving.[36]

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[32] Ryan, Rosemary, et al. *Arrestee Estimates of Substance Abuse Treatment Need (ARREST) Study*. Olympia, WA: Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services. Report No. 4-22. September, 1997.

[33] Schlesinger, Mark, Robert Dowart, Robin Clark. "Public Policy in a Fragmented Service System." in *Drug Abuse Services Research Series No. 1*. National Institute on Drug Abuse, U.S. Department of Health and Human Services. 35.

[34] Schlesinger, Mark, Robert Dowart, Robin Clark. "Public Policy in a Fragmented Service System." in *Drug Abuse Services Research Series No. 1*. National Institute on Drug Abuse, U.S. Department of Health and Human Services. 35, 36-37.

[35] *Healthy People 2010 Objectives: Draft for Public Comment.* Office of Public Health and Science, U.S. Department of Health and Human Services. Sept. 15, 1998. 26-22.

[36] Ezeh, Alex and Beth Sundberg. *Uniform Facility Data Set (UFDS): Data for 1996 and 1980-1996.* Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, December, 1997. 27.

Similarly, inpatient capacity, although easily determined by the number of beds available in a 24-hour period, is difficult to link to measures of need. Differences in what the term "inpatient" is used to refer to renders comparison among studies problematic. In addition, while practices in the private sector have been moving away from residential chemical dependency treatment programs for adults (to correct a legacy of perhaps unnecessary costly stays made possible by funding stipulations no longer applicable), the trend in publicly funded programs remains in the direction of providing appropriate care for a different clientele, one frequently lacking the family, financial and health resources which help make outpatient care effective.

But anecdotal evidence of long waiting periods, and the little hard data available, indicate a large and perhaps growing gap between need for treatment and system capacity for patient relying on public funds. For example, the survey of state residents during FY 1994 indicated that 11.1 percent of Washington residents whose income was 200 percent below the federal poverty level currently needed substance abuse treatment; in that time period, DASA programs served only 21 percent of that number. In other words, 8 of 10 state residents living in poverty who needed treatment for chemical dependency presumably did not receive it, in part because numbers of treatment programs and slots available were inadequate in comparison to the numbers of people in need.[37] Similarly, some 68 percent of the total prison population in Washington State has been identified as chemically dependent at the time of reception; funding levels allow less than one-quarter of those who need treatment to actually participate in it.[38] Publicly funded residential (inpatient) chemical dependency treatment programs for indigent and low-income youth are also inadequate in size; on June 18,1999, for example, 196 youth aged 13 to 17 were on waiting lists for some 165 beds. The average wait for admission to an inpatient program able to serve a young person with both chemical dependency and emotional, behavioral and/or other mental health problems was two to four weeks–too long for a troubled adolescent.[39]

Reliable information is simply not available regarding private treatment program capacities, and the relation of those capacities to need, in Washington State. Owners of these facilities and services generally define descriptive, fiscal and client data as proprietary. Although information about treatment modalities is available for certified services, counts of numbers served and outpatient "slots" and other data that would enable assessment of availability of treatment relative to need are simply not obtainable. Some states, notably Minnesota, do require all service providers to report at least some private-pay client data; at this time, Washington does not.

Access to Treatment Services: Financial Considerations

In Washington State, as in the U.S. as a whole, an individual's access to chemical dependency treatment is shaped in large part by his or her ability to pay.[40] Income requirements regulating eligibility, the limited availability of slots within a particular eligibility category, and the targeted nature of some funding determine who has how much opportunity for publicly funded treatment. As noted earlier, current program funding levels provide service to roughly one in five adults in this population group who need treatment for substance abuse and addiction.

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[37] Kabel, Joseph, et. al. *Substance Use, Substance Use Disorders, and Need for Treatment in Washington State Adults: Findings from the 1993-1994 Washington State Needs Assessment Household Survey*. Olympia, WA: Office of Research and Data Analysis, Washington State Department of Social and Health Services. Report No. 4.25-40. December, 1996. 32, 40.

[38] *Division of Offender Programs, Chemical Dependency Services 1996 Annual Report*. Washington State Department of Corrections. PO 161 Chemical Dependency Services Annual Report DOOP 4/97. December, 1996. 5.

[39] Communication from Sue Green, At-Risk/Runaway Youth Coordinator, Washington State Division of Alcohol and Substance Abuse, Olympia, Washington. June 21, 1999.

[40] *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* Public Health Service. U.S. Department of Health and Human Services. 172-173.

The following population segments receive special emphasis for treatment interventions, based on stipulations tied to state and federal funding sources: pregnant women and women with children, families with children, injection drug users, people with HIV/AIDS, youth, and recipients of child welfare and child protective services.[41]

Some 75 percent of Washington's adult residents report income amounts that disqualify them for most publicly funded treatment programs (because their incomes are above 200percent of federal poverty levels). When these residents–who total in number 1,540,803–need substance abuse and addiction treatment, they must pay for it with money from other sources (private health insurance, savings, etc.).[42] Insurance coverage limits often determine the amount and type of treatment these residents can access. At present, a number of insurance carriers "carve out" what they deem "behavioral health coverage" for mental health and substance abuse treatment, setting benefit limits which are smaller than the coverages they provide for general health conditions. A company may cover unlimited lifetime expenditures for treatment of asthma or diabetes, for example, but set arbitrary limits on duration or dollar amounts of coverage relative to substance abuse and dependency treatment. Data has not been collected in Washington State to determine how many people who continue to need treatment after reaching the carve out limits simply go without, and how many eventually end up–given the economically downwardly-mobile nature uninterrupted chemical dependency disease–in publicly-funded treatment programs.

The minimum chemical dependency treatment service coverage required of state-regulated group health care policies will soon change. As of January 1, 2000, administrative rules will require group health insurance policies to provide "medically necessary" chemical dependency services, as defined by the Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II (*American Society of Addiction Medicine, 1996*), and a maximum benefit of $10,000 in a 24 consecutive calendar month period, with no lifetime benefit cap. These are the only state requirements affecting the financial dimension of treatment access available through private pay,[43] and apply only to the roughly 40-50 percent of the state population whose employers purchase state-regulated group health plans.[44] Other insurance plans may provide substance abuse treatment benefits, but are not required to do so by the state.

Nearly one in ten (9.2 percent) of Washington residents said in 1998 that they had no health insurance.[45] According to an earlier study, the state's Hispanic population, and the state's "working poor" are the two groups least likely to have health coverage.[46] Unless these people did in fact qualify for insurance, or for publicly funded treatment services–or could afford to pay for those services on their own–they presumably did not have access to treatment for substance abuse or chemical dependency.

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[41]Beretta, Gina R. *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State*. Olympia, WA: Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services. DSHS 22-055 (Rev 1/99). January, 1999. 109-111.

[42] Estimates provided by John Yoachim, Research and Data Analysis, Washington State Department of Social and Health Services, August 20, 1999. Based on federal census and state population forecast information.

[43] Washington Administrative Code. WAC 284-53 "Standards for Coverage of Chemical Dependency."

[44] Don Sloma, Deputy Insurance Commissioner, Health Policy Division, Washington Office of the Insurance Commissioner. Telephone conversation May 4, 1999.

[45] *1998 Washington State Population Survey*. Washington's Office of Financial Management. <http://www.wa.gov/ofm/sps/cur_in~1.htm>.

[46] McCluskey, Richard E. "Fact Sheet: Insurance Status and Demand for Substance Abuse Treatment." Conference presentation for the 5th Annual Joint Conference on Health, October 7, 1998. Data from the 1993-1994 Washington State Needs Assessment Household Survey.

Additional Considerations: Client Characteristics

A number of entities have expressed concern that treatment for substance abuse and chemical dependency be available to all specific population groups, including those underserved by the national medical system as a whole. "Due regard for age and ethnic and gender diversity," specifically in relation to a managed treatment continuum, is one of the Washington State Board of Health's key principles intended to increase "accountability, efficacy, and cost effectiveness in reducing the misuse of alcohol and other drugs."[47] The unofficial national health promotion objectives published in *Healthy People 2000* identify groups of particular concern as people with low incomes, women (especially pregnant women and mothers with young children), youth, minorities and inmates in correctional facilities.[48] Another listing, this one in a publication by the federal Center for Substance Abuse Treatment, adds to the list medically ill populations (especially those affected by infectious diseases such as HIV/AIDS, tuberculosis, and hepatitis), disabled people, persons with mental disorders, the homeless, prostitutes, and elderly people.[49] [d] Additional groups, such as lesbian women and gay men, may also be underserved due to various social factors related to accessibility.

Stipulations tied to both federal and state funds in effect determine which special populations will be served by Washington State's public treatment moneys administered through DASA: pregnant women and women with children, families with children, injection drug users, people with HIV/AIDS, youth, and recipients of child welfare and child protective services. Because of the lack of information available about private treatment programs, it is not possible to assess treatment availability for specific groups of people who need treatment for substance abuse and addiction, but do not qualify for publicly funded access to treatment services.

The case of Native Americans and treatment for chemical dependency in Washington State illustrates some of the complexities of service access and provision for special populations, complexities that can extend even beyond program funding.[e] Native American people residing in Washington state are unusual among specific population groups in that many have access to substance abuse treatment through tribal providers or via Indian Health Services (IHS) funding in addition to general private pay and publicly-funded program options. DASA's 1999 listing of chemical dependency treatment services identifies 43 "Native American treatment and prevention providers," 27 of which are certified to receive public funds channeled through DSHS.[50]

Results of the FY 1994 state survey of adults living in households indicated that Native Americans as a group had the highest need for treatment, although the proportion of Native Americans with incomes above 200 percent of the federal poverty level who currently needed treatment was not significantly different from the need in other similar groups (13.2 percent of non-indigent Native Americans compared to 10.8 percent of non-indigent whites, for example, who also revealed a current need for treatment). The proportion among indigent Native Americans rose to 21.4 percent, however, a statistically significant difference from other indigent population groups. (In the indigent group with the next highest proportion, whites, 12.3 percent

[47] *1998 Washington State Public Health Report*. Olympia, WA: Washington State Board of Health, 1998. 42.

[48] *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* Public Health Service. U.S. Department of Health and Human Services. 172-173.

[49] Crowe, Anne H. and Rhonda Reeves. *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination*. Technical Assistance Publication Series 11. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. DHHS Publication No. (SMA) 94-2075.1994. Chapters 6 and 7.

[50] *Directory of Certified Chemical Dependency Treatment Services in Washington State: March 1999*. Olympia, WA: Division of Alcohol and Substance Abuse, Department of Social and Health Services. U-1 to U-3.

currently needed treatment).[51] Anecdotal information from professionals experienced in working with this population indicate that treatment programs tailored to specific historical and cultural conditions make treatment more effective–a tailoring sometimes difficult to accomplish given lack of adequate funding, and a perennial shortage of appropriately-trained counselors. In addition, access to treatment is complicated by culturally-influenced understandings of effective interventions in illness and disease, communication and transportation issues (many Native Americans living in Washington's rural areas do not have reliable access to telephones, for example), attitudes toward bureaucracy, and the narrow focus of some treatment approaches which do not take into account individual and family membership in larger communities. According to treatment professionals, the fact is that despite somewhat enhanced access to treatment (represented by tribal programs and IHS funding) Native Americans in this state continue to suffer a pandemic of chemical dependency, which among indigent Native Americans is significantly out of proportion to the incidence of substance abuse in other indigent population groups.

Treatment's Place in Substance Use/Abuse Intervention Efforts

Effective intervention for substance use and addiction involves a variety of efforts, ranging from primary prevention to formal treatment (See page 4 of this paper). Prevention, treatment, and law and justice activities are generally viewed by Washington State's public substance abuse professionals as three equally important sides of the intervention triangle. These approaches frequently overlap in what until recently might have been considered unexpected places. For example, a 1995 survey of Washington's local law enforcement jurisdictions revealed that 99 percent of the state's 5th and 6th graders live in jurisdictions where DARE training is provided by law enforcement personnel to at least some classes, and 59 percent of the 138 officers interviewed said they would like their jurisdiction to be even more involved in prevention.[52] Law and justice professionals have also begun to be involved in treatment efforts through drug court and deferred prosecution programs allowing treatment sentencing alternatives.

Nationally, a number of people and entities presently attempt to intervene in both individual and social patterns of alcohol and drug abuse. A federal Center for Substance Abuse Treatment model depicts a coordinated system composed of those with input into a macro level of policy-making, and a micro level of direct intervention with individuals. While this model has debatable aspects (for example, it visually isolates policy-making from actual intervention), it illustrates the point that in the complex meshing of substance abuse and efforts to intervene in it, coordination is necessary to provide most efficiently the most successful–that is, the most comprehensive and continuing–treatment services to people affected by chemical abuse and dependency.[53]

[51] Kabel, Joseph, et. al. *Substance Use, Substance Use Disorders, and Need for Treatment in Washington State Adults: Findings from the 1993-1994 Washington State Needs Assessment Household Survey*. Olympia, WA: Office of Research and Data Analysis, Washington State Department of Social and Health Services. Report No. 4.25-40. December 1996. 35.

[52] Kelleher, Tedd. *Reducing Substance Abuse in Communities: Local Law Enforcement Efforts and Preferred Enhancements*. Olympia, WA: Washington State Community, Trade and Economic Development. July, 1995. v.

[53] Crowe, Anne H. and Rhonda Reeves. *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination*. Technical Assistance Publication Series 11. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. DHHS Publication No. (SMA) 94-2075. 1994. 153-154.

A Systems Model for Decision making and Intervention[54]

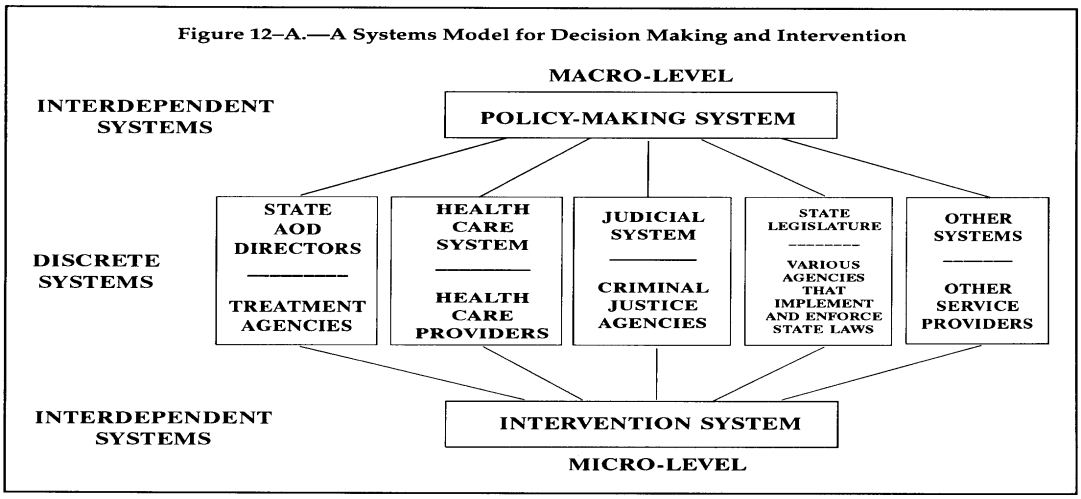

Table 12–A.—Structural and Service Coordination

Structural Coordination	Coordination of Services
Goal development	Patient identification
Needs and resources assessment	Patient assessment and treatment case planning
Funding	Patient treatment matching and referral
Development of other resources (e.g., treatment programs, staff, facilities)	Treatment interventions (comprehensive and continuing)
Program evaluation	Monitoring and case reporting

State law assigns DSHS planning and coordination duties relative to public and private "agencies, organizations, and individuals" related to the "treatment of alcoholics and other drug addicts and their families".[55] The Division of Alcohol and Substance Abuse receives input in analyzing service needs from their Citizen's Advisory Council, a broad-spectrum group representing those impacted by substance abuse.

Several other cooperative bodies also work to fight substance abuse in Washington State. The Governor's Council on Substance Abuse provides one opportunity for the state's public and private sector leaders to work together to develop common goals and make recommendations for policy, research, and program strategies. Four state legislators, the directors of seven major state agencies and 15 representatives of private industry, local and tribal government, treatment providers, law enforcement, education, and community groups make up council membership. In addition, the proposal selection processes structured around allocating money from several granting programs also consider prevention, treatment, and law and justice concerns.

[54] Crowe, Anne H. and Rhonda Reeves. *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination*. Technical Assistance Publication Series 11. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. DHHS Publication No. (SMA) 94-2075. 1994. 154.
[55] RCW 70.96A.050., 060, 070.

Community Mobilization funds (state and federal dollars administered by Washington State Community, Trade and Economic Development) support community designed and administered efforts against substance abuse and violence; these programs bring citizen and agency representatives together in each of the state's 39 counties. Finally, representatives of state agencies which contract for treatment services meet with those from other agencies with substance abuse-related responsibilities in the Washington Interagency Network Against Substance Abuse, a voluntary group which meets regularly and publishes *FACE IT*, a networking newsletter.

Policy Guidelines Relative to Access to Substance Abuse and Chemical Dependency Treatment

Official Washington state policy regarding treatment for "alcoholism, intoxication and drug addiction," as spelled out in RCW 70.96A.010, reads as follows:

> . . . alcoholics and intoxicated persons . . . should, within available funds, be afforded a continuum of treatment in order that they may lead normal lives as productive members of society. Within available funds, treatment should also be provided for drug addicts.

The Governor's Council on Substance Abuse was established by executive order in 1994, to respond to the significant human, social and economic costs substance abuse inflicts on individuals, families, and communities in Washington State. The Council's long-term goals related to treatment are as follows:[56]

1. Increase access to and availability of chemical dependency treatment, as clinically necessary.
2. Reduce the negative effects of alcohol, tobacco, and other drugs.
3. Address the basic needs of people in chemical dependency treatment.

Recommendations from other relevant Washington state board and commissions affirm the need for and importance of treatment, and at times identify suggested target populations, but follow the lead of state law in failing to specify target percentages or treatment program capacity in relation to need.[57]

Recently "parity"–defined by the National Conference on State Legislatures as "equalizing health insurance coverage between behavioral health and other medical services"[58]–became a matter for national discussion. Congress passed the Mental Health Parity Act of 1996, which went into effect January 1, 1998, and Senator Paul Wellstone (D-MN) and Representative Jim Ramstad (R-MN) introduced a substance abuse parity bill in Congress during September 1997.

The federal Office of National Drug Control Policy (ONDCP) issued a statement in May 1999, which strongly supports parity for substance abuse treatment as one facet of effective national drug control policy. According to ONDCP, parity would help close the national treatment access gap by resulting in an opportunity to expand capacity.

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[56]Governor's Council on Substance Abuse. *1999-2000 Priority Recommendations to Reduce Substance Abuse in Washington State.* August 1998. Olympia, WA: Washington State Community, Trade and Economic Development.
[57]See Appendix A for listings of related recommendations from the Washington State Board of Health, Washington State Governor's Council on Substance Abuse, 1998 National Drug Control Strategy, and the draft Healthy People 2010 objectives.
[58] "Fact Sheet: Parity," Washington, D.C.: Health Policy Tracking Service, National Conference of State Legislatures. October 23, 1998.

Recent estimates of the average insurance premium increases as a result of full parity for substance abuse treatment range from 0.2 percent,[59] or one dollar per month for most families,[60] to $5.11 per member per year ($.43 per member per month) in managed care environments.[61] A March 1999 SAMSHA report found that 86 percent of employers who made changes to comply with the Mental Health Parity Act did not make compensatory changes in benefits (such as dropping mental health coverage altogether) because they assessed anticipated cost increases as non-existent.[62] Based on all of this data, ONDCP concluded that [full substance abuse treatment] parity is an important step forward in the effort to make treatment affordable and available to those who need it. Access to treatment is a key element of any successful anti-drug abuse strategy.[63]

Gaps in Treatment Services

The following "gaps" in substance abuse treatment availability in Washington State were identified during research for this white paper. Treatment recommendations made by the Governor's Council on Substance Abuse appear at the end of this section.

- Drug courts have proven to be very effective in breaking the cycle of drug-related crime and the associated criminal justice and social costs. However, funds are not available to implement drug courts throughout the state, and existing drug courts receiving federal support will soon lose their funding.

- Prison and jail treatment programs are extremely short on capacity. The former serves only about 18percent of the need. In addition, community-based continuing care services for which those treated qualify after release–such as outpatient treatment, employment services, childcare, public transportation, and affordable alcohol and drug-free housing–are in very short supply.

- At present the state funds one secure treatment facility for adults and one for youth. Involuntary commitment public treatment facilities should be located in both Eastern and Western Washington, one for adults and another for youth on each side of the state.

- Detoxification program access is inadequate in most Washington counties.

- Current opiate substitution programs cannot meet current need. Regulations should allow providers more flexibility, giving them authority to expand as necessary to meet need. In addition, physician-based dispensing should be funded and evaluated as a possible solution to inadequate capacity.

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[59] Sing, Merrile, et.al.. *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits.* Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. DHHS Publication No. (SMA) 98-3205. March, 1998. 31, 33.

[60] "Office of National Drug Control Policy Statement on Parity for Substance Abuse Treatment." Washington, D.C.: Office of National Drug Control Policy, Executive Office of the President. May 5, 1999. 2.

[61] Sturm, Roland, Weiying Zhang and Michael Schoenbaum. "How Expensive Are Unlimited Substance Abuse Benefits under Managed Care?" *The Journal of Behavioral Health Services & Research*. 26:2. May, 1999. 207, 209.

[62] Buck, Jeffrey. "SAMHSA Backgrounder: Effects of Mental Health Parity Act of 1996." Office of Managed Care, Substance Abuse and Mental Health Services Administration. U.S. Department of Health and Human Services. March, 1999. 2, 4.

[63] "Office of National Drug Control Policy Statement on Parity for Substance Abuse Treatment." Washington, D.C.: Office of National Drug Control Policy, Executive Office of the President. May 5, 1999. 1-4.

- A nationwide shortage of chemical dependency treatment professionals is also a problem here in Washington. This could be partially addressed by expanding training opportunities. At this time, only Central Washington State University offers the four-year degree in addiction treatment studies, which would allow counselors to earn competitive compensation.

- Washington's public treatment services have the capacity to serve an estimated one-fifth of the need. The percentage of unmet need is higher in the following areas, because the current capacity is lower:

    - Individuals with co-occurring disorders–chemical dependency and learning language disabilities, chemical dependency and traumatic brain injuries, chemical dependency and mental illness.
    - Deaf and hearing-impaired individuals.
    - Gay, lesbian, bisexual and transgender individuals.
    - Non-English speaking individuals.
    - Elderly individuals.

- There are no treatment programs in the state dedicated to pregnant adolescent girls nor are there treatment programs that provide on-site child-care for girls who are parenting small children. As a result, the few pregnant or parenting adolescent girls that do receive treatment receive in adult treatment settings, which is far from ideal for both the adult women and adolescents being served.

- Quality control regarding access to private-pay treatment is presently initiated by consumer complaints. There is no data concerning to what extent people who have insurance actually receive treatment.

Recommendations

These priority treatment recommendations of the Governor's Council on Substance Abuse, developed by the Council in 1998, represent only a portion of the steps necessary to address the unmet treatment need in Washington State. Implementation of these recommendations would be a small but strong step toward healthier communities.

- Expand capacity of involuntary treatment services for chemically dependent and mentally ill adults to provide services in Eastern Washington.
- Enhance grants to Indian tribes for treatment and prevention programs.
- Increase secure treatment capacity for chemically dependent, female youth.
- Improve access and capacity for youth detoxification and crisis stabilization services.
- Expand the availability and capacity of drug courts.

Detailed descriptions of these recommendations are contained in Appendix A.

The Council also made the following treatment-related research recommendations in 1997:

Substance Abuse and Welfare Reform
- Refine the substance abuse prevalence estimates among welfare recipients.
- Determine the service configuration (treatment/vocational services) that results in the most favorable employment outcomes.

Child Welfare

- Determine the impact of treatment and prevention services on child welfare costs.
- Determine the need for treatment among Child Protective Services clients (both caretakers and children).
- Determine whether traditionally underserved populations (i.e., the poor, ethnic minorities, women) have access to appropriate chemical dependency services within the BHP.

Evaluation of the Chemical Dependency Treatment Benefit Within the Basic Health Plan

- Identify outcomes and cost offsets that follow from chemical dependency treatment within the BHP, especially cost offsets to other medical expenses.
- Determine outcomes and cost-offsets of chemical dependency treatment in subsequent medical expenses.

A detailed description of these recommendations is contained in Appendix B.

The Governor's Council on Substance Abuse encourages allied systems to partner and collaborate with the alcohol and drug treatment systems to leverage resources in an effort to create efficiencies across multiple systems.

APPENDIX A—1998 GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE PRIORITY TREATMENT RECOMMENDATIONS

1. Expand the Capacity of Involuntary Treatment Services for Chemically Dependent and Mentally Ill Adults to Provide Services in Eastern Washington

Funding of this recommendation would provide Eastern Washington residents with access to involuntary treatment services and services for dual-diagnosis adults that are currently available only in Western Washington.

Description

Add 15 involuntary treatment beds for adults committed under the ITA (Involuntary Treatment Act: RCW 70.96A) and a 20-bed residential program for mentally ill chemical-abusing (MICA) adults in Eastern Washington. There is currently only one such facility in the state, located in Sedro Woolley, and this has long waiting lists for admission.

Fiscal Detail

The current cost per day of adult inpatient treatment, according to the Division of Alcohol and Substance Abuse, is $127.

Total Cost	**FY 2000**	**FY 2001**	**Total**
	$ 1,622,000	$ 1,622,000	$ 3,244,000

Performance Measure Detail

Outcome Measures

Creating the two-inpatient units in Eastern Washington has the potential to reduce the revolving-door pattern of mentally ill substance abusers and those who need involuntary treatment. The specialized programs, with their longer stays and programming to suit the patients' particular needs, have a better chance of producing long-term changes in the patients' behaviors.

Output Measures

The involuntary commitment law allows committing an individual for 60 days, with a 90-day renewal provision. The average length of stay for a patient in a MICA facility is one year. With a $1.622 million annual appropriation, the additional 35 beds for these two programs would enable treatment of 95 ITA patients per year and 84 individuals in the MICA category.

Efficiency Measures
Creating a total of 35 additional beds in Eastern Washington for these two programs will reduce the expensive and ineffective use of inappropriate facilities such as hospital emergency rooms and Eastern State Hospital, and will also decrease the time and expense for local governments across the state to transport individuals to Sedro Woolley.

Narrative Justification and Impact Statement

Reason for Change
RCW 70.96A requires that chemical dependency treatment resources be available and adequate to involuntarily commit individuals to treatment through the Involuntary Treatment Act (ITA). The Division of Alcohol and Substance Abuse (DASA) presently contracts with Pioneer Cooperative Affiliates to operate a 65-bed secure, involuntary treatment program for chemically dependent adults on the grounds of the Northern State Multi-Service Center in Sedro Woolley.

Eastern Washington has no resources for alcoholics/addicts who need to be involuntarily committed to treatment. Access to the Sedro Woolley facility is severely limited for residents of Eastern Washington because of long waiting lists and significant transportation costs. Eastern Washington residents are therefore likely to end up in hospital emergency rooms or in the mental health system at Eastern State Hospital, which is not appropriate for this population.

The only inpatient treatment program for Washington residents who are both mentally ill and chemically dependent is the MICA (Mentally Ill, Chemically Abusing) facility at Sedro Woolley. This program, which is voluntary, also has long waiting lists and the same logistical difficulties posed by its location.

DASA hopes to be able to co-locate the 15 ITA beds and the 20 MICA beds at Medical Lake, to reduce baseline costs and facilitate access to treatment.

Impact on clients and services
Provision of the 35 specialized beds will significantly reduce the waiting lists for these categories of chemically dependent people–who are particularly unstable and may pose a danger to themselves and others while waiting for treatment.

Effects of non-funding
Individuals who need involuntary treatment, and/or are mentally ill as well as chemically dependent, will continue to be ineffectively served at other facilities and/or will struggle with the long waiting list at the state's only specialized programs at Sedro Woolley.

2. Enhance Grants to Indian Tribes for Treatment and Prevention Programs

This recommendation would enhance the current allocation to Indian Tribes from $18,000 to $48,000 per year to provide a more adequate base for substance abuse treatment and prevention services.

Description

Support continuous, outcome-focused, comprehensive prevention and treatment programming for Washington's 27 federally recognized tribes by allocating an additional $30,000 per year to each, in a manner consistent with the current practice of supporting counties' programming.

Fiscal Detail

Total Cost	**FY 2000**	**FY 2001**	**Total**
	$ 810,000	$ 810,000	$ 1,620,000

Performance Measure Detail

Outcome Measures
An employment outcome monitoring process by the Department of Social and Health Services, and the Department of Employment Security found that 31 percent of the Native Americans who completed chemical dependency treatment were employed one year following discharge. Their average wage at that point was $10.10.

Output Measures
These are difficult to determine at this point, since each tribe will make decisions about how to use its allotment. DASA expects that most of the funds will be dedicated to prevention programs.

Narrative Justification and Impact Statement

Reason for Change
Substance abuse and addiction are at pandemic levels among Native American people. While American Indians represent only two percent of the Washington population, they comprise over 10 percent of the Division of Alcohol and Substance Abuse's treatment population. The Need for Treatment study published by the Department of Social & Health Services in December 1996 reported that Native Americans had the highest need for treatment of all the state's racial/ethnic groups at 17.1 percent. Whites were second, at 11.1 percent.

The Need for Treatment report indicated that only 21 percent of the need for substance abuse and treatment services across the state was being met by the state allocation to county government. (This study analyzed patterns among residents who were poor enough to qualify for publicly funded treatment).

At the time the data was collected, in 1993-94, there were more than 5,000 indigent Native Americans in Washington who fit the criteria for being in need of substance abuse treatment.

DASA currently allocates $18,000 per year to each tribe for prevention services and/or outpatient treatment programs, which is used by most to fund annual prevention-related "events." An additional $30,000 per tribe will make it possible to develop more effective prevention programming on an ongoing basis, using professional staff.

Impact on clients and services

The additional funds dedicated to prevention programs should help reduce the long-term need for treatment services. In the short run, it may increase the demand for treatment if the new programs heighten awareness and break down resistance to treatment.

A 1997 cost savings study indicated that indigent individuals who receive chemical dependency treatment use, on average, $4,500 less in medical care in the five years following treatment than do abusers/addicts who remain untreated. This funding has significance for the State's Medicaid budget.

Effects of non-funding

The notorious cycle of addiction will continue to be a major factor in tribal life. The average age at death for Native Americans is the early 50s, and substance abuse is a major factor in this short life span. According to DASA, 17 percent of adult Native Americans currently need substance abuse treatment compared to 10 percent of the total population. Among poor adults, 21 percent of Native Americans currently need substance abuse treatment, compared to 11 percent of poor persons in general.

3. Increase Secure Treatment Capacity for Chemically Dependent Female Youth

This recommendation is to fund 16 secure treatment beds for "Becca-eligible," female youths.

Description

Provide 16 secure Level II youth residential treatment beds for "Becca-eligible" female youths: those who are incapacitated by alcohol and other drugs; have their judgment so impaired that they are incapable of making rational decisions with respect to the need for treatment; present a likelihood of serious harm to themselves or others; and are at high risk to run from treatment.

Fiscal Detail

Total Cost	**FY 2000**	**FY 2001**	**Total**
	$ 1,072,000	$ 1,022,000	$ 2,094,000

Performance Measure Detail

Outcome Measures
A treatment outcome evaluation published in 1997 and based on 1996 data indicated that 90 percent of Becca-eligible youth had run away from home in the year prior to treatment. After treatment, 21 percent ran away–which demonstrates that treatment can be successful for this category of youth, if they can be kept in a secure environment that maximizes the likelihood of their completing a treatment program.

Output Measures
DASA estimates that the additional beds will enable treatment of 420 adolescents per year.

Narrative Justification and Impact Statement

Reason for Change
The current continuum of care lacks capacity for secure treatment of female youth who are high-risk, runaway, and low-income. There is one locked 16-bed facility for males who fit these criteria. Provision of 16 beds specifically for young women would bring the Division of Alcohol and Substance Abuse into compliance with the intent of the original Becca Runaway Youth Legislation. (The bill was named after a chemically dependent, multiple problem youth who died while on the run in Spokane. Her story highlighted the fact that chemically dependent adolescents, especially those who are emotionally disturbed and/or otherwise at risk, are not capable of making rational decisions about their needs. The provision of locked treatment facilities is often the only way to intervene in their self-destructive behavior patterns.)

Impact on clients and services
Provision of the 16 beds will give treatment professionals and parents an additional, safe option for female adolescents in this particularly difficult and dangerous category. It could slightly decrease ineffective use of other, non-secure treatment programs, and slightly increase the use of after-care services as the clients complete the residential phase of treatment.

Effects of non-funding
Treatment resources will be wasted as young women are placed in treatment only to run away. More significantly, these youth will continue to become victims of deprivation, crime, and suicide because they are too disabled to be helped through less-drastic programs. Only parents wealthy enough to afford private secure facilities will be able to obtain effective treatment for their children.

4. Improved Access/Capacity for Youth Detoxification/Crisis Stabilization Services

This recommendation seeks to decrease the waiting period for youth crisis stabilization services by increasing the current capacity from 10 to 20 beds.

Description

Increase by 10 additional beds the availability of detoxification/crisis stabilization services, which have proven successful in addressing the needs of homeless, at-risk, runaway and street youth who have serious effects of intoxication, withdrawal, and other co-existing mental health and emotional problems.

Fiscal Detail

The cost of these services is $200 per client per day, according to the Division of Alcohol and Substance Abuse (DASA).

Total Cost	**FY 2000**	**FY 2001**	**Total**
	$ 780,000	$ 780,000	$ 1,560,000

Performance Measure Detail

Outcome Measures
A 1996 study by DASA shows 77 percent of the youth assessed in the detoxification/crisis stabilization process needed residential treatment. Another 18.7 percent were diagnosed as needing outpatient treatment. The data also indicates that nearly 70 percent of the youth assessed in the detoxification/crisis stabilization process were admitted immediately to treatment. Another 15 percent were placed on waiting lists.

Output Measures
About 40 youth per month are being served in the current sites. The sum requested by the Division of Alcohol and Substance Abuse would double the number to 80.

Narrative Justification and Impact Statement

Reason for Change
Youth who are otherwise eligible for either chemical dependency or mental health services are often denied entry to these programs because they are intoxicated or are in a crisis that includes aggressive and/or out-of-control behaviors that could put themselves or others in danger. Thus their very serious problems prevent them from getting treatment.

Detoxification/crisis stabilization services provide a safe, stable environment for evaluating and preparing these adolescents for successful referral to the treatment services they desperately need. DASA currently funds a total of 10 beds for detoxification and stabilization; they are located at eight sites around the state.

Impact on clients and services
Clients will experience a more "seamless" progression from detoxification/stabilization to treatment, and fewer will be lost in those transitions.

Effects of non-funding
The present average wait for a detoxification/crisis stabilization bed is six weeks–not a reasonable time frame for unstable, out-of-control adolescents. Therefore, the youth who most need treatment will sometimes not receive it because of their behaviors and their inability to wait for an opening.

5. Expand the Availability and Capacity of Drug Courts

This proposal will provide resources to counties for planning of new drug courts, assistance in maintaining existing drug courts, and support of courts that are losing federal funding

Description

The offender population has a very high rate of involvement with substance abuse. The study, *Behind the Bars: Substance Abuse and America's Prison Population*, reports that nationally, approximately 81 percent of the offender population have involvement with substance abuse. The Washington study *The Arrestee Estimates of Substance Abuse Treatment Need* reports that a very high number of arrestees at three adult prison sites are in need of substance abuse treatment, 56 percent in Yakima County, 65 percent in King County, and 79 percent in Whatcom County. There are minimal resources for this population.

In the state of Washington, there are drug courts currently operating in Spokane, Pierce, King, and Thurston counties. At the same time, additional counties have recently received new federal funds (Clark, Cowlitz, Lewis, Kitsap, Skagit, Yakima, and Whatcom). However, there continues to be a critical need for state resources for this underserved population.

National interest in drug courts began when the first drug court began operation in Dade County, Florida, in 1989. The collaborations between the justice and treatment systems epitomized by drug courts may offer considerable hope for long-term reduction in drug-related crime, and lower jail and prison populations. The drug court model differs in important ways from previous efforts by providing drug treatment to offenders with underlying drug problems. In the drug court model, various components of the criminal justice and substance abuse treatment systems work together to try to use the coercive power of the court to promote abstinence and pro-social behavior. In comparison, those persons who do not enter into drug courts unfortunately receive short jail sentences, with little treatment or close community supervision. Drug courts are a much more productive option for offenders needing treatment.

The key components of drug courts are:

- Drug courts integrate alcohol and other drug treatment services with the justice system case processing;

- Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights;

- Eligible participants are identified early and promptly placed in the drug court program;
- Drug courts provide access to a continuum of alcohol, drug, and related treatment;
- Abstinence is monitored by frequent alcohol and other drug testing;
- A coordinated strategy governs drug court responses to participants' compliance;
- Ongoing judicial interaction with each drug court participant is essential;
- Monitoring and evaluation measure the achievement of program goals and gauge effectiveness;
- Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations; and
- Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

Fiscal Detail

Total Cost	**FY 2000**	**FY 2001**	**Total**
	$ 3,020,000	$ 2,980,000	$ 6,000,000

Expenditure Calculations and Assumptions
Calculations are based on the average costs of drug court services presently in place. It is assumed that these funds will support drug court services in five to seven counties. Counties may have one to two case managers, depending on the size and numbers of clients served. Program activities and treatment cost were calculated based on a total of 500 to 1,800 clients served.

Narrative Justification and Impact Statement

Impact on clients/services
Drug courts in the State of Washington generally serve:

- Offenders charged with felony drug possession, prescription forgery and some non-violent property offenses;
- Offenders with no prior violent or sex offense convictions, and who are not drug dealers or known gang members; and
- Offenders who have been evaluated as serious drug addicts and are amenable to participating in a rigorous treatment program.

Drug courts are effective. A recent review of the research on drug courts nationally by Steven Belenko, National Center on Addiction and Substance Abuse at Columbia University, reports

that “drug courts provide closer, more comprehensive supervision and much more frequent drug testing and monitoring during the program, than other forms of community supervision. More importantly, drug use and criminal behavior are substantially reduced while offenders are participating in drug court.”

The funds for drug courts will be available to counties planning for new drug courts, assistance in implementing existing drug courts, and supporting those courts that are losing federal funds.

APPENDIX B—GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE 1997 TREATMENT RECOMMENDATIONS

Substance Abuse and Welfare Reform

Prepared for the Governor's Council on Substance Abuse
Research Priorities
By Toni Krupski
Division of Alcohol and Substance Abuse
Washington Department of Social and Health Services

Overview
In 1996, welfare reform legislation was passed which limits welfare assistance to five years and requires able-bodied adults to work after two years. Although the new law requires states to put welfare recipients to work, many will be unable to work because of alcohol and drug problems. Failure to deal with this group effectively could cripple welfare reform efforts in Washington State.

Significance
National estimates are that between 15 percent and 27 percent of adults receiving Aid to Families with Dependent Children (AFDC–the largest federal welfare program) are in need treatment for alcoholism or drug abuse. Without chemical dependency treatment or collateral vocational services, it is likely that few of these persons will become employed.

For example, preliminary studies conducted in Washington State indicate that fewer than 15 percent of untreated indigent substance abusers earned more than $320 per month over a 4½-year period. In comparison, almost 30 percent of indigent substance abusers that received chemical dependency treatment earned more than $320 per month over this same time period and almost 50 percent who received both treatment and adjunct vocational services earned this amount.

Although these data point to the importance of providing both chemical dependency treatment and vocational rehabilitation services to substance abusing welfare recipients, more information is needed to identify both, specific service needs and more specific prevalence estimates particular to Washington State.

Current Discussion Points
The federal law allows states to exempt 20 percent of their welfare caseloads from the work requirement as hardship cases. Experts speculate, however, that pregnant women, women with children, or people with disabilities other than addiction will take up most of these exemptions. Thus, it is likely that thousands of individuals with alcohol and other drug problems will have to be put to work.

Recommendations
Provide funding to:

1. Refine the current prevalence estimate and to tailor it specifically to Washington State.
2. Determine the service configuration (chemical dependency treatment/vocational services) that results in the most favorable employment outcomes for different types of addicts/alcoholics.

Child Welfare

Prepared for the Governor's Council on Substance Abuse
Research Priorities
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Overview
Alcohol and other drugs are consistently found associated with interpersonal violence. Child abuse is perhaps the most egregious form of such violence. According to a recent report, Child Protective Services (CPS) staff received a total of 74,638 referrals in 1995. About 56 percent were accepted by CPS, involving 45,206 separate victims.

Child welfare workers have long been aware of the large number of substance dependent parents among their caseloads. This impression has been recently verified by data from the Washington State Office of Children's Administration Research, which shows that:

- 67 percent of caretakers of children removed from the home have substance abuse issues, as do approximately 15 percent of children under the age of 12;
- Infants born to the relatively small population of low-income substance abusing women account for a large share of CPS referrals and out-of-home placements;
- 44 percent of infants born to substance abusing women are reported at "high-risk" of imminent harm; and
- 18 percent of infants born to substance abusing women are placed out of home.

Significance
Despite this clear link between substance abuse and child neglect/abuse, there is very little information available about the impact of chemical dependency treatment and prevention on child welfare service utilization and costs. Such information would be essential in formulating strategies to ameliorate the violence against children that exists in our state.

In addition, it would be useful to have more precise prevalence rates of substance abuse among Division of Children and Family Services (DCFS) clients (caretakers and children).

Recommendations
Provide funding to:

- Determine the impact of chemical dependency treatment and prevention services on child welfare service utilization and costs; and
- Determine the need for treatment among DCFS clients (both caretakers and children).

Evaluation of the Chemical Dependency Treatment Benefit within The Basic Health Plan

Prepared for the Governor's Council on Substance Abuse
Research Priorities
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Overview

Today, the U.S. health care system is undergoing a period of rapid change that will profoundly affect how alcohol and other drug treatment is funded and delivered. Most prominent in this change is the move to treat publicly funded substance abuse clients through managed care initiatives.

Managed care promises many benefits including cost savings and increased focused on outcomes. It also carries significant risks. For example, clients in the publicly-funded system are often poor, have little political clout, and have serious needs and problems not typically covered in private managed care plans. There is real question about whether the multi-problemed, publicly funded client's needs will be met under managed care.

Effective January 1, 1996, a managed care plan for the state of Washington, the Basic Health Plan (BHP), added chemical dependency to its schedule of benefits. Individuals with family incomes at or below 200 percent of the federal poverty level became able to purchase this coverage at subsidized rates. Coverage also became available to individuals with family incomes above 200 percent of the poverty level who were able to purchase it through the BHP at non-subsidized rates.

At present, enrollees are eligible to receive a maximum benefit of $5,000 for covered inpatient, residential and outpatient chemical dependency treatment in a 24 consecutive calendar month period and up to a lifetime maximum of $10,000.

Significance

The introduction of the BHP into Washington provides an unprecedented opportunity to examine the ability of managed care to serve chemically dependent public clients in Washington State. Questions such as whether the multi-problemed public client (including special populations) has access to appropriate services will be critical. Other questions regarding outcomes of clients and cost offsets that result in other medical services as a result of participation in chemical dependency services will also be important to examine. Because the BHP is an integrated model, including both chemical dependency and other medical services, it provides an ideal system for such an examination. Previous studies conducted in Washington State show significant reductions in subsequent medical expenses among alcoholics and drug addicts who participate in chemical dependency treatment.

Recommendations
Provide resources to:

- Determine whether traditionally underserved populations (i.e., the poor, ethnic minorities, women) have access to appropriate chemical dependency services within the BHP;
- Identify outcomes and cost offsets that follow from chemical dependency treatment within the BHP, especially cost offsets to other medical expenses; and

Determine outcomes and cost-offsets of chemical dependency treatment in subsequent medical expenses.

Endnotes

a. The state of Washington conducted an assessment of need for substance abuse treatment services in 1993-1994. The Washington State Needs Assessment Household Survey (WANAHS) utilized funds from the federal Center for Substance Abuse Treatment (Substance Abuse and Mental Health Services Administration) to conduct telephone interviews of adults from 7,000 Washington households. This figure does not include adults not living in households when the survey was conducted–for example, those homeless, and state residents living at the time in institutions and group situations such as hospitals, prisons, and shelters. It is, however, the only such survey of Washington's general population, and still relatively recent.

b The United Facility Data Set Survey is an annual one-day census of specialty substance abuse treatment facilities across the U.S., administered by the Substance Abuse and Mental Health Services Administration of the federal Department of Health and Human Services. Some 85percent of such facilities reported data for October 1, 1996, on which the information provided here is based. Although a number of questions have been raised about the usefulness of such episodic and voluntary reporting, the UFDS data is the only source presently available which includes private treatment providers.

c High rates of drug use in the arrestee population continue. Interview and urinalysis data from Seattle arrestees, collected from July 1998 to December 1998, reveals that 65percent of adult males and 81percent of adult females tested positive for at least one illegal drug. In Spokane, 62percent of male and 68percent of female arrestees had positive tests. [“62 percent of male arrestees and 68 percent of female arrestees test positive for illegal drugs at arrest: Spokane” and “65 percent of male arrestees and 81 percent of female arrestees test positive for illegal drugs at arrest: Seattle.” Office of Justice Programs, National Institute of Justice. n.d.]

d More information about disability and substance abuse is available from the Resource Center on Substance Abuse Prevention and Disability, 1331 F Street NW, Ste. 800, Washington, DC 20004. See especially their paper entitled "An Overview of Alcohol and Other Drug Abuse Prevention and Disability."

e For an overview and assessment of DSHS services to Native Americans, see Division of Alcohol and Substance Abuse Administrative Policy 7.01 Odd Year Plan, April 2, 1999.

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